POLST

Physician Orders for Life-Sustaining Treatment

Guidance for Health Care Providers

developed by the
Physician Orders for Life-Sustaining Treatment
Task Force

Introduction

People have the right to make their own health care decisions. Oregon's advance directive document can help people communicate their treatment preferences when they would otherwise be unable to make such decisions. Unfortunately, the wishes expressed by an advance directive may in some cases not be honored due to the unavailability of completed forms or a provider's lack of understanding of how to translate the language of the document into treatment of specific medical conditions. Providers caring for persons in various health care settings may in good faith initiate or withhold treatments that are potentially medically inappropriate or contrary to the desires of the person.

The "Physician Orders for Life-Sustaining Treatment" (POLST) is a document designed to help health care providers honor the treatment wishes of their patients. The document was developed over a four-year period and is updated periodically by a multi-disciplinary task force convened by the Center for Ethics in Health Care, Oregon Health & Science University, with representatives from numerous health care provider and institutional organizations. The POLST is designed to help primary care physicians and nurse practitioners, long-term care facilities, hospices, home health agencies, emergency medical services, and emergency physicians:

- promote patient autonomy by documenting a person's treatment preferences and coordinating these with physician orders;
- enhance the authorized transfer of patient records between facilities;
- clarify treatment intentions and minimize confusion regarding a person's treatment preferences;
- reduce repetitive activities in complying with the Patient Self Determination Act;
- facilitate appropriate treatment by emergency medical services personnel; and
- encourage parents of minor children or guardians of minors or protected persons to express wishes and intentions for treatment.

The voluntary use of the POLST document is intended to enhance the quality of a person's care and is expected to complement the advance directive if it has been completed. The POLST document is a short summary of treatment preferences and a physician's order for care that is easy to read in an emergency situation. The POLST is not intended to replace an advance directive document or other physician orders. It centralizes information, facilitates record keeping, and ensures transfer of appropriate information among health care providers and care settings.

The Oregon Board of Medical Examiners has defined the Scope of Practice so that an Oregon-certified First Responder or EMT shall comply with life-sustaining treatment orders executed by a physician or nurse practitioner [OAR 847-35-0030(6)].

Several resources have been developed to help implement the POLST. This pamphlet includes a sample of the POLST form and a step-by-step explanation of each section of the document. The document is available at cost and may be ordered using the order form provided in this information packet. Other resources available upon request include teaching materials, a summary of research about POLST's effectiveness, evaluation projects, a patient/resident brochure, and consultation with health care professionals skilled in the use of the form through the OHSU's Center for Ethics in Health Care. To access these resources call (503) 494-4466, email at ethics@ohsu.edu or contact the Center's Web site at www.ohsu.edu/ethics.

How To Implement The Physician Orders For Life-Sustaining Treatment Form

Overview

The Physician Orders for Life-Sustaining Treatment (POLST) form should be completed after discussion with the person* or surrogate decision-maker regarding treatment preferences. The document may be completed by other health care professionals under the direction of the attending physician or nurse practitioner. The attending physician/nurse practitioner must sign the form assuming full responsibility for its accuracy.

The POLST has seven sections (A through G) on a double-sided bright pink form. One side of the document contains the "Physician Orders for Life-Sustaining Treatment" (Sections A - E). The other side of the form explains how and when to update the POLST form. Section F has the "Patient/Resident (Parent of minor child) Preferences as a Guide for this POLST Form" and Section G has the "Review of this POLST form." Wallet cards are also available that summarize the completed POLST document. These cards may be useful for persons who may spend time outside an institution or home care setting. The wallet card is an addition to, not a replacement for, the POLST form. A completed and signed POLST form must exist for the wallet card to be valid. The POLST and wallet card are printed on medium-weight bright pink colored paper to ensure an easily recognizable form that is standard from one care setting to another.

Title and Patient/Resident Identification

The POLST provides documentation of a person's preferences and provides life-sustaining treatment orders which reflect these values. In health care facilities, the POLST should be the first document in the clinical record. In other settings, it is recommended that the form be placed inside a red envelope (to protect privacy) and attached to the front of the refrigerator. While the original form should accompany the person upon transfer from one setting to another, a copy of the POLST should be kept in the individual's medical record.

Section By Section Review Of The POLST Form

Physician Orders

This section lists four different medical treatments or services including: Section A - Resuscitation, Section B - Medical Interventions, Section C - Antibiotics, and Section D - Artificially Administered Fluids and Nutrition. Section E summarizes the medical condition for the physician/nurse practitioner orders and signature and contact information of the attending physician/nurse practitioner.

If the person requires treatment, the caregiver should first initiate any treatment orders recorded on the POLST, and then contact the attending physician/nurse practitioner. Any order section that is not completed indicates that full treatment should be provided for that section until clarification is obtained.

* "person" is used throughout this booklet to indicate an adult inpatient or outpatient, a resident of a long term care facility or the parent or guardian of a minor child.

Section A - Resuscitation

The Resuscitation section refers only to the circumstance in which the person has no pulse and is not breathing. This section does not apply to any other medical circumstances. For example, this section does not apply to a person in respiratory distress because he/she is still breathing. Similarly, this section does not apply to a person who has an irregular pulse and low blood pressure because he/she has a pulse. For these situations, the health care provider should refer to Sections B, C and D - described below and follow the appropriate orders.

If the person wants cardiopulmonary resuscitation (CPR) and CPR is ordered, then the "Resuscitate" box is checked. Full resuscitation measures should be carried out and 9-1-1 should be called. If a person has indicated that he/she does not want CPR in the event of no pulse and no breathing, then the "Do Not Resuscitate (DNR)" box is checked. Resuscitation should not be attempted. The person should understand that comfort measures will always be provided and no resuscitation efforts would be given.

Pediatric Considerations

Remember, since arrest in most cases in children is primarily respiratory, a child is more likely to be found with a pulse for a longer period of time than an adult. If a child has any respiratory effort or pulse the child should be treated as directed under Section B.

Section B - Medical Interventions

This section refers to emergency medical circumstances for a person who has a pulse and/or is breathing. This section provides orders for situations that are not covered in Section A and were developed in accordance with EMS protocol. If full treatment by EMS is indicated and desired, the "Full Treatment" box is checked. In medical emergencies, 9-1-1 is called. However, if the person and physician/nurse practitioner determine that some limitation is preferred, then only one of the other boxes is checked. Health care providers will first administer the level of EMS services ordered and then contact the attending physician/nurse practitioner. Comfort care is always provided regardless of indicated level of EMS treatment. Other instructions may also be specified.

The level of interventions are as follows:

Comfort Measures Only indicates a desire for only those interventions that enhance comfort. In general, the person and physician/nurse practitioner would not want an EMS response unless necessary for patient comfort. Oxygen and manual treatment of airway obstruction may be used for comfort. The person would not expect to be transported to a hospital unless indicated later by the attending physician or nurse practitioner because acute care skills are needed to enhance comfort (e.g. to treat intractable pain).

Limited Additional Interventions indicates that EMS is called in the event of emergent circumstances and provides limited additional treatment. The emergency medical technicians will consider the use of cardiac monitoring and oral/IV medications. Endotracheal intubation or long term life support measures are not used and the attending physician/nurse practitioner is notified. Transfer to hospital may be indicated, but usually not intensive care.

Full Treatment indicates no limitation of treatment and all support measures needed to maintain and extend life will be utilized. All treatments described above will be provided, along with the use of endotracheal intubation, electrical cardioversion and other advanced cardiac life support measures as appropriate for the person's clinical condition. Other instructions may be written in to individualize treatment.

Section C - Antibiotics

This section records whether a person wishes to be treated with antibiotics. If antibiotics are desired, the attending physician/nurse practitioner checks the "Antibiotics" box. If no antibiotics are desired, the "No antibiotics" box should be checked. There is also space for further instruction on the use of antibiotics.

Section D - Artificially Administered Fluids and Nutrition

This section allows the physician/nurse practitioner to record a person's instructions regarding artificially administered fluids and nutrition for a person who cannot take fluids by mouth. ORS 127.505 to 127.660 presumes that every incapable person has consented to artificially administered hydration and nutrition, other than hyperalimentation.

This legal presumption of consent is overcome if:

- The person as a capable adult specifically stated that he/she would have refused artificially administered fluids and nutrition; or
- The person appointed a health care representative and has given the representative the authority to make decisions regarding artificially administered nutrition and hydration.

The presumption can also be overcome for an adult or child under either of the following circumstances:

- When the person does not have an advance directive or a health care representative, as long as the person is permanently unconscious, or has a terminal illness, or is in the advanced stage of a progressive illness, permanently unable to communicate, cannot recognize friends and family and cannot swallow food and water safely; or
- When the administration of nutrition and hydration is not medically feasible or would itself cause severe, intractable or long lasting pain.

While Oregon law allows a person a choice about artificially administered fluids and nutrition, **oral fluids and nutrition must always be offered to the person if medically feasible.** If the person wants a long term feeding tube or IV fluids, that box is checked. If there are limitations ordered for artificially administered fluids and nutrition, either the "No feeding tube/IV fluids" box or the "Defined trial period of feeding tube/IV fluids" box is checked. Other instructions may also be specified.

Section E - Basis for Physician Orders

Upon completion of the physician orders, the attending physician/nurse practitioner checks the box indicating with whom the orders were discussed (i.e., patient/resident, parent of minor, health care representative, court-appointed guardian, spouse or other). The attending physician/nurse practitioner then writes a short statement about the person's medical condition. For example, the physician/nurse practitioner might write, "The patient has terminal lung cancer complicated by end-stage heart failure."

For a child, either custodial parent or a guardian has the authority and responsibility to consent or refuse consent to health care for minors who are unable to consent for themselves. A minor who is 15 years of age or older may consent or refuse consent for health care.

At the bottom of the page, the physician/nurse practitioner must sign the form. The physician/nurse practitioner then prints his/her name, day and evening phone numbers, and the date the orders were written. If the physician/nurse practitioner does not sign the form it cannot be treated as a valid order and EMS personnel cannot limit EMS services. Phone orders may be taken by nursing staff (per institutional or community protocol) and later counter signed by the physician/nurse practitioner. Such orders are valid in the interim.

The top and bottom of the form include reminders that the original form should accompany the person whenever transferred or discharged. It allows the receiving facility to have the same information regarding the medical indications and person's preferences for life-sustaining treatment and increases the likelihood that these orders will be respected in the new care setting.

How To Update The POLST Form

The back of the form explains how to change the POLST orders and when to review the order form. Although the POLST form itself is periodically revised to change its utility, there is no need to replace earlier versions of the POLST form with new versions unless the person's wishes or conditions have changed. Providers, including EMS, should continue to follow prior versions of the form.

Section F - Patient/Resident (Parent of Minor Child) Preferences as a Guide for this POLST Form

The patient/resident has personal values that may be expressed orally, in writing (such as an advance directive) or by a surrogate (health care representative or court-appointed guardian or parent of a minor). We encourage attaching copies of advance directives or guardianship documents to the form. The physician/nurse practitioner should carefully consider these individual preferences when completing and reviewing the life-sustaining treatment orders. The form cannot be completed without a conversation between the physician/nurse practitioner and the patient/resident or surrogate. If the person's preferences or medical status changes, the POLST should be re-evaluated. The person or their surrogate may sign this section indicating agreement with the orders, but the individual's signature is optional. Some persons may not be able to sign the form. If the form is prepared by someone other than the attending physician/nurse practitioner, the preparer must record their signature, name, and date of preparation.

Section G - Review of this POLST Form

This section records the review of POLST if a person's preferences or medical status change. The orders should also be reviewed by the attending physician/nurse practitioner (or designee) immediately after the person is transferred from one care setting to another, periodically, or as determined by the care setting. This review includes the date, the reviewer's name and the location of the review. The outcome of the review is also recorded by checking either the box indicating no change or one of the two boxes indicating the old form has been voided and a new form completed or not completed. The reviewer may also wish to record why the form was voided. With any change, the form should be voided by drawing a diagonal line and/or the word VOID across the front of the form. After voiding the form, a new form should be completed reflecting the new medical indications and treatment wishes of the person.

POLST Wallet Card

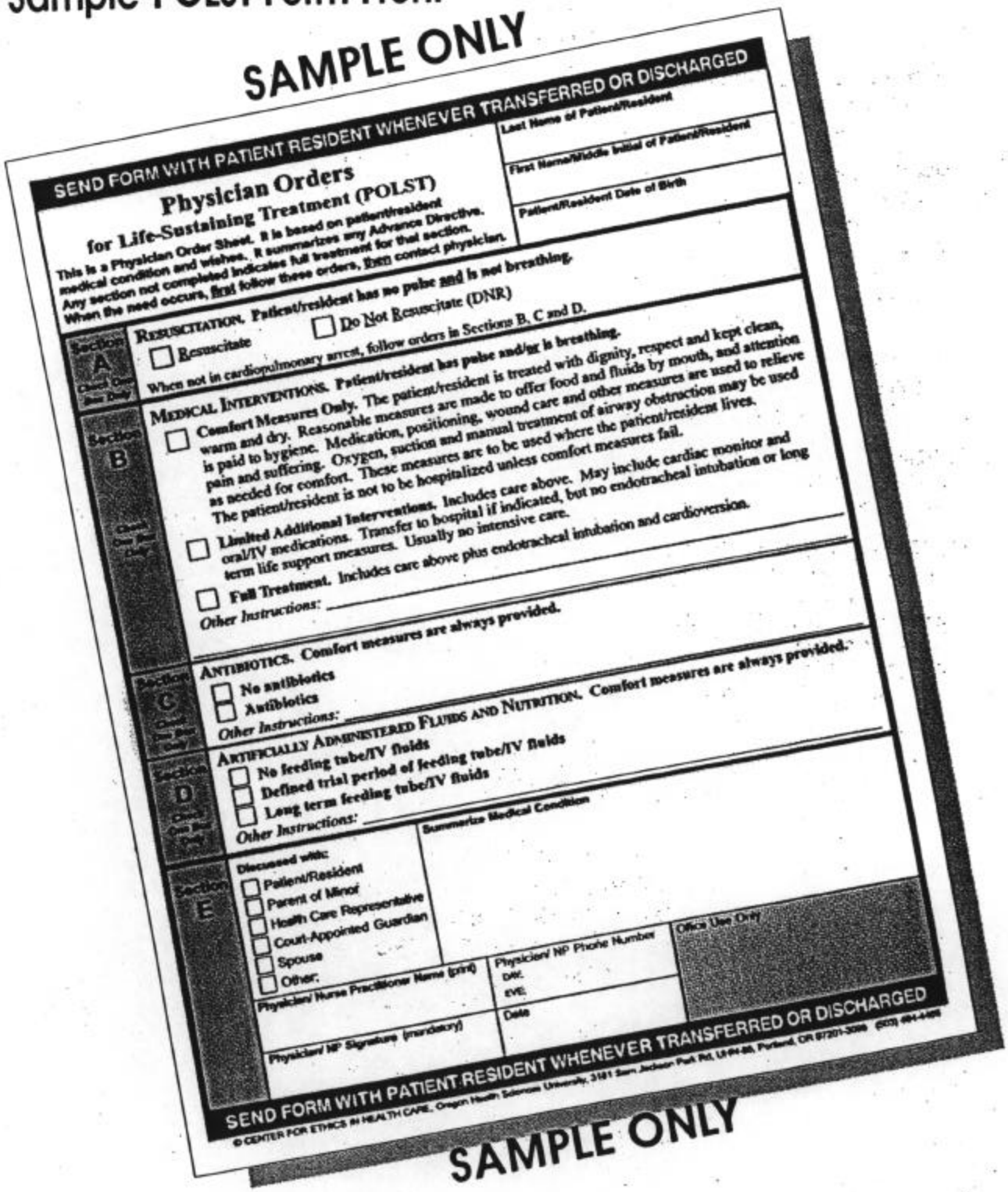
A wallet card of the POLST is also available to summarize physician/nurse practitioner orders. The wallet card is optional and may be useful to some individuals. This card is not a substitute for a completed POLST document. It provides a summary of the POLST document and is expected to be honored by care providers. The physician/nurse practitioner must sign both the POLST document and the wallet card to make the wallet card valid.

Brochure for Patients and Families

A separate brochure describes the POLST Program for patients and families. The description encourages communication among patients and their providers and completion of advance directives. Because the POLST form is oriented to health care professionals, patients are referred to their provider for further information about the form. The Center for Ethics in Health Care will provide POLST information to the provider upon request.

Many provider and institutional organizations have endorsed the POLST for voluntary use. For a list of these organizations or for further information or questions, please contact the Center for Ethics in Health Care, Oregon Health & Science University, at (503) 494-4466 or see the Web Site at www.ohsu.edu/ethics

Sample POLST Form Front



Shown at reduced size; actual size is 8½" x 11".

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NURSING PROCEDURE

DRAFT

POLST form
(Physician Orders for Life-Sustaining Treatment)

OBJECTIVE:

The POLST form is a "portable" Physician Order form that describes the patient's code directions. It is intended to go with the patient from one care setting to another. It also replaces the current EMS form that gives code directions to emergency response staff in a patient's home. It translates an Advance Directive into physician orders.

Note: The POLST is not an Advance Directive and does not take the place of one. It translates an Advance Directive into physician orders. Patients should still be encouraged to fill out an Advance Directive if they do not have one.

METHOD:

Patient Admitted to SHMC with a POLST form:

- The RN will review and validate the POLST form content with the patient/surrogate. This information will be conveyed to the admitting physician and code status orders obtained for this hospital admission.
- Staff will honor the directions on the POLST form while the nurse attempts to reach the physician to clarify code status/orders (not to exceed 24 hours) unless the patient or surrogate indicate they do not want those directions followed.
- No Code / Limited Code orders will be documented on SHMC's green No Code / Limited Code order sheet per procedure.
- Make a copy of the POLST form, addressograph and place in the Legal/Directive section of the patient's chart.
- Place original POLST order form in the designated plastic sleeve in the Legal/Directive section of the patient's chart and retain there until the patient is discharged.
- Make a check mark on the patient's Personal Inventory Record (clothing sheet) indicating that this patient has a POLST form and the original needs to be sent with the patient at time of discharge/transfer from SHMC.
- Make a check mark on the Personal Inventory Record to indicate that the POLST form was sent with the patient at time of discharge. Also record the POLST form was sent with the patient on the Discharge Checklist if the patient is transferred to another care facility/provider.

Completing a POLST form while a patient at SHMC

- If a patient/surrogate chooses to complete a POLST form prior to being discharged from SHMC, obtain a POLST form for the Physician and patient/surrogate to complete and sign.
- Make a copy of the completed POLST form/addressograph the copy and place in Legal/Directive section of chart.
- If patient is actively being prepared for discharge, place original POLST form with copies being made for discharge and send with patient at time of discharge.
- If patient will not be transferred or discharged for a period of time, place the completed original POLST form in the designated plastic sleeve in the Legal/Directive section of the chart. Make a check mark on the Personal Inventory Record indicating that this patient has a POLST form and that the original needs to be sent with the patient at time of discharge/transfer from SHMC.

- Make a check mark on the Personal Inventory Record to indicate that the POLST form was sent with the patient at time of discharge. Also record the POLST form was sent with the patient on the Discharge Checklist if the patient is transferred to another care facility/provider.

Review of POLST form

- The physician and patient/surrogate may review/revise the POLST form at anytime by using the designated section of the form or voiding the old form and completing a new one.
- During discharge planning, the physician may wish to review the POLST to see if it needs revision or the patient's condition warrants review/revision prior to discharging home or transferring patient to another care facility/provider such as home health/hospice etc.

New 8/00

A Method to Communicate Patient Preferences About Medically Indicated Life-Sustaining Treatment in the Out-of-Hospital Setting

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OBJECTIVE: Patient preferences for life-sustaining treatment are frequently unknown at critical moments, which often results in clinicians providing treatment that is not medically indicated and/or may not be consistent with patient desires. A consortium of Oregon health care professionals developed the *Medical Treatment Coversheet* (MTC) to standardize documentation of patient preferences in the out-of-hospital setting by having corresponding physician orders available at the patient's location. We describe a unique process of development, evaluation, and implementation of the MTC.

DESIGN: First, we conducted focus groups of providers to help draft the MTC. Second, the accuracy of MTC interpretation was determined by cohorts of acute and long-term care providers by indicating their treatment approach to three hypothetical written scenarios. They responded to the same scenarios twice, with and without the MTC. Responses were compared with each other and with ideal responses (most medically appropriate and in agreement with patient preferences) as defined by an expert panel. Finally, we are instituting pilot projects and developing a plan for statewide voluntary implementation of the MTC.

SETTING: Urban and rural long-term care facilities and emergency medical service systems in Oregon.

PARTICIPANTS: Focus groups included 28 general internists practicing in urban and rural settings and five nurses working in a long-term care facility. In addition, 87 providers (19 primary care physicians, 20 emergency physicians, 26 paramedics, and 22 long-term care nurses) participated in the evaluation of the form by responding to hypothetical scenarios. Providers in long-term care facilities in both an urban and rural area helped with pilot implementation of the MTC. Use of the MTC in noninstitutional settings was not evaluated.

MAIN OUTCOME MEASURES: Suggestions from focus groups were incorporated into the form. For the hypothetical scenario responses, ideal appropriateness scores were analyzed, with a total possible score of 30 for each acute care provider and 15 for each long-term care provider. Statistically significant differences were determined using a paired *t* test. We report the experience of providers who helped with the pilot implementation of the form.

RESULTS: Focus groups would use the MTC and believed it would be useful for their patients. Comparing responses to the hypothetical scenarios without the MTC to those with the MTC, 37% of treatment decisions changed for acute care and 29% changed for long-term care providers. Changes were attributable overwhelmingly to withholding treatments consistent with patient preferences. Compared with the ideal, decisions were more appropriate for all specific treatments across all scenarios and clinician groups with the MTC, with one exception: some advanced emergency treatments were withheld inappropriately by 18% of acute care providers with the MTC, (chi-square = 15.94, $P < .0001$). For all scenarios combined, appropriateness scores increased significantly with the MTC for both acute care (16.4 to 22.3, $P < .0001$) and long-term care providers (8.8 to 12.2, $P < .0001$). Overall, providers helping with the pilot implementation were satisfied with the document, organizational endorsements, and available informational resources.

CONCLUSION: We describe our process for development, initial evaluation, and implementation of the MTC. In clinical scenarios overall, the MTC improves the appropriateness of clinicians' decisions about life-sustaining treatments. We are planning statewide implementation of the MTC after appropriate education of clinicians. **J Am Geriatr Soc 44:785–791, 1996.**

In 1991 a federal law was enacted requiring health care institutions to provide patients with information about advance directives. Unfortunately, do-not-resuscitate (DNR) orders associated with these advance directives may be effective only while the patient resides in the institution where the order was written. Transfer from the institution creates a need to communicate patient treatment preferences about medically indicated life-sustaining treatments to other healthcare providers. Often this communication need is not fulfilled, and patients receive treatments that are contrary to their wishes and/or not medically indicated.[1] Recently, the SUPPORT principal investigators indicated that "proactive and forceful measures" may be needed to improve patient

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A Prospective Study of the Efficacy of the Physician Order Form for Life-Sustaining Treatment

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OBJECTIVES: The Physician Orders for Life-Sustaining Treatment (POLST), a comprehensive, one-page order form, was developed to convey preferences for life-sustaining treatments during transfer from one care site to another. This study examined the extent to which the POLST form ensured that nursing home residents' wishes were honored for Do Not Resuscitate (DNR) and requests for transfer only if comfort measures fail.

DESIGN: The study used chart record data to follow prospectively a sample of nursing home residents with the POLST.

SETTING: Eight geographically diverse, long-term, adult-care facilities in Oregon in which the POLST was in use.

PARTICIPANTS: Nursing home residents (n = 180), who had a POLST recording DNR designation and who indicated a desire for transfer only if comfort measures failed, were followed for 1 year.

MEASUREMENTS: For all subjects: treatment and disposition after significant health status changes; orders for narcotics and for provision or limitation of aggressive interventions. For hospitalized subjects: diagnosis, medical interventions, and DNR orders. For those who died: cause and location of death, life-sustaining treatments attempted, and comfort measures provided.

RESULTS: No study subject received CPR, ICU care, or ventilator support, and only 2% were hospitalized to extend life. Of the 38 subjects who died during the study year, 63% had an order for narcotics, and only two (5%) died in an acute care hospital. A total of 24 subjects (13%) were hospitalized during the year. Hospitalized subjects' mean length of stay was 4.9 days, and the mean rate of hospitalizations for all subjects was 174 per 1000 resident years. In 85% of all hospitalizations, patients were transferred because the nursing home could not control suffering. In 15% of hospitalizations (n = 4), the transfer was to extend life, overriding POLST orders.

CONCLUSIONS: POLST orders regarding CPR in nursing home residents in this study were universally respected. Study subjects received remarkably high levels of comfort care and low rates of transfer for aggressive life-extending treatments. **J Am Geriatr Soc 46:1097–1102, 1998.**

Americans are concerned with the quality of care that they receive at the end of life.[1] Both professional journals and the popular press document evidence of medicine's proclivity toward intensive care.[2–4] Cardiopulmonary resuscitation (CPR) and intensive care unit (ICU) care are often provided during life's final months even when the patient's or family's preference is for comfort care rather than life-extending treatments.[3, 5] Surveys reveal the personal distress of nurses and physicians about their frequent involvement in overly aggressive treatment of the dying.[6] These concerns have led to appeals for increased advance care planning and better documentation of treatment refusal.[1, 7]

Of equal concern are medicine's inadequacies in pain and symptom management. Many physicians have not received adequate training in this aspect of care.[1] An estimated 40 to 80% of nursing home residents have ongoing pain that contributes to functional impairment and decreased quality of life.[8–12] For many nursing home residents, pain is controlled poorly because of poor tolerance of nonsteroidal anti-inflammatory drugs and low rates of narcotic use.[13] A recent study of 12 nursing homes in Massachusetts confirmed that only 15% of residents had an order for any form of opioid narcotic, and most of those orders were limited to acetaminophen with codeine.[14] Ferrell and colleagues found that 71% of nursing home residents had chronic painful conditions, and most were given acetaminophen.[10] Sengstaken and King reported that rates of analgesic use are even lower in nursing home residents who are noncommunicative.[11]

For editorial comment, see p 1170

If patients truly wish to limit life-extending treatment and have the focus of care on their comfort, the real issue, particularly for those in long-term care, is not CPR but whether to transfer nursing home residents to the hospital.[15] Success rates with CPR in nursing homes vary from 0 to 5%.[16–18] Success rates approach zero when an older person has an unwitnessed out-of-hospital arrest. Of those who

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Physician Orders for Life-Sustaining Treatment (POLST): Outcomes in a PACE Program

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OBJECTIVES: To evaluate whether terminal care was consistent with Physician Orders for Life-Sustaining Treatment (POLST), a preprinted and signed doctor's order specifying treatment instructions in the event of serious illness for CPR, levels of medical intervention, antibiotics, IV fluids, and feeding tubes.

DESIGN: Retrospective chart review.

SETTING: ElderPlace, a Program of All-Inclusive Care for the Elderly (PACE) site in Portland, Oregon.

PARTICIPANTS: All ElderPlace participants who died in 1997 were eligible (n = 58). Reasons for exclusion were no POLST (1), missing POLST (1), and insufficient documentation of care (2).

MEASUREMENTS: POLST instructions for each participant and whether or not each of the treatments addressed by the POLST was administered in the final 2 weeks of life.

RESULTS: The POLST specified "do not resuscitate" for 50 participants (93%); CPR use was consistent with these instructions for 49 participants (91%). "Comfort care" was the designated level of medical intervention in 13 cases, "limited interventions" in 18, "advanced interventions" in 18, and "full interventions" in 5. Interventions administered were at the level specified in 25 cases (46%); at a less invasive level in 18 (33%), and at a more invasive level in 11 (20%). Antibiotic administration was consistent with POLST instructions for 86% of 28 subjects who had infections in the last 2 weeks of life, and less invasive for 14%. Care matched POLST instructions in 84% of cases for IV fluids and 94% for feeding tubes.

CONCLUSIONS: POLST completion in ElderPlace exceeds reported advance directive rates. Care matched POLST instructions for CPR, antibiotics, IV fluids, and feeding tubes more consistently than previously reported for advance directive instructions. Medical intervention level was consistent with POLST instructions for less than half the participants, however. We conclude that the POLST is effective for limiting the use of some life-sustaining interventions, but that the factors that lead physicians to deviate from patients' stated preferences merit further investigation. J Am Geriatr Soc 48:1–6, 2000.

Key words: advance directives; end-of-life care; withholding; withdrawing life-sustaining treatment; do-not-resuscitate orders

Patients may prevent medical personnel from administering life-sustaining treatment that they do not want by using advance directives. Advance directives, however, have several limitations. First, only 15–20% of Americans complete them.[1] Interventions to improve the rate of advance directive use have not been successful.[2] Second, physicians are often unaware of their patients' wishes or ignore the instructions in advance directives, and patients themselves sometimes change their minds about what they had previously specified when they become seriously ill.[2,3–7] Third, an advance directive must be translated into a doctor's order to be implemented. If such an order has not been written in advance of a life-threatening illness, emergency medical interventions and hospitalization may occur before healthcare professionals take information in an advance directive into account.

In 1994, an Oregon multidisciplinary task force attempted to address these problems by developing a preprinted physician order form called Physician Orders for Life-Sustaining Treatment (POLST).[8] When a patient is too sick to make decisions, the POLST specifies what a physician is to do in four categories of medical treatment: (1) CPR; (2) the level of medical intervention (ranging from comfort care at home to intensive hospital treatments); (3) antibiotic use; (4) feeding tubes and IV fluids (long term or short term). Patients keep the original POLST with them in the event of an emergency. A primary purpose of specifying "level of medical intervention" is to prevent hospitalization during the dying process if the participant wants to receive comfort care at home. Emergency medical systems, hospitals, and long-term care facilities within Oregon officially recognize a completed POLST as a legitimate basis for withholding specific treatments, even in an emergency.[9] The POLST accompanies a patient who is transferred to a hospital or nursing home.

Providence ElderPlace is one site of the national Program of All-Inclusive Care for the Elderly (PACE). It is a fully capitated managed care organization that provides compre-

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